

Learning and Behavior Disorders In Children

Skilled kindergarten teachers, psychologists, and informed parents have begun to recognize the potential "problem child" early in his school career. Advice and counseling by the physician and the administration of medications can be of inestimable benefit to such children.

From the educational point of view, distractibility and short span of attention are the most significant characteristics of these children who have been given a wide variety of labels including hyperkynesia, dyslexia, hypokynesia, minimal brain damage, minimal brain dysfunction and others.

A detailed developmental history, filled out by the parents at home, can save the physician time and will suggest areas of investigation. The physical examination will usually present only the so-called "soft signs," such as poor coordination, poor balance, poor performance of finger-to-nose or heel-to-shin. Some physicians and psychologists place great emphasis on the finding of awkward dyskinetic creeping.

The hyperkinetic child is benefited by the administration of sympathomimetic drugs. Amphetamines have the advantage of being available in long-acting dosage form. Ritalin® (methylphenidate) has the advantage of a better quality of control and a higher percentage of success. Stimulant drugs do not produce euphoria in hyperkinetic children and are, therefore, non-habituating.

Responsible administration of helpful medications to children with learning and behavior disorders is not scandalous but rather highly desirable and commendable. There is a need for more widespread and more specific application of medical and pharmacological assistance in the problem of learning and behavior disorders.

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REFERENCES

- Millichap JG: Drugs in management of hyperkinetic and perceptually handicapped children. *JAMA* 206:1527-1530, Nov 11, 1968
Whitsell LJ: Learning disorders as a school health problem. *Calif Med* 109:433-445, Dec 1969

Increasing Problem of Malaria

Malaria is the most prevalent disease in the world today — 200,000,000 cases annually. The disease is seen throughout the world, especially in Asia. When one considers how many servicemen are rotated from this area each year, the number of cases in the United States is remarkably small, considering that the *Anopheles* mosquito is present in many areas of the United States.

The ideal method of protection of both the returning soldiers and the population in this country requires the continuation of preventive medication for a period of two months after return from an endemic area. This is rarely done, and perhaps of more significance is the fact that for the two million civilian tourists, malaria protection is rarely, if ever, practiced.

As several recent articles have indicated, the number of domestic cases is increasing. There were 54 reported cases of malaria in the United States in 1959, and slightly more than 3,000 cases in 1970. Although most of these cases were associated with returning servicemen, an interesting sidelight of the disease is the transmission to civilians by the use of needles for heroin injection. This method of infection has been implicated in one recent episode in Central California.

In our search for disease and in its treatment one should keep in mind that malaria is far from uncommon in the jet age; and in cases involving periodic spikes of fever, especially if associated with anemia, this ancient disease should be considered in the differential diagnosis, especially since the falciparum variety may be fatal and require somewhat specific therapy.

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REFERENCES

- Jacobs J, Bramblett J: Malaria, the blood and the clinician. *Am Fam Physician GP* 1:58-65, Jan 1970
Barrett-Connor E: Malaria—An "imported" disease to be reckoned with in the U.S. *Calif Med* 115:19-24, Aug 1971